Arizona Medical Board

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FINAL MINUTES FOR REGULAR SESSION MEETING
Held on October 10, 2007 and October 11, 2007
9535 E. Doubletree Ranch Road · Scottsdale, Arizona

Board Members

William R. Martin III, M.D., Chair
Douglas D. Lee, M.D., Vice Chair
Dona Pardo, Ph.D., R.N., Secretary
Dan Eckstrom
Robert P. Goldfarb, M.D., F.A.C.S.
Patricia R. J. Griffen
Ram R. Krishna, M.D.
Todd A. Lefkowitz, M.D.
Lorraine L. Mackstaller, M.D.
Paul M. Petelin Sr., M.D.
Germaine Proulx
Amy J. Schneider, M.D., F.A.C.O.G.

Call to Order
The meeting was called to order at 9:30 a.m.

Roll Call
The following Board Members were present: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Dr. Pardo, Ms. Proulx, and Dr. Schneider. The following Board Member was absent: Mr. Eckstrom.

Call to Public
Le Roi Baez, M.D. addressed the Board during the call to public. He informed the Board he has complied with the requirements of his Board Order and requested the Board lift the chaperone requirement. He said he has voluntarily changed his practice by having a staff member with him at all times when seeing patients and; therefore, does not believe the chaperone requirement is necessary.

All other statements issued during the Call to Public appear beneath the case referenced.

Executive Director's Report
Timothy Miller, J.D., Executive Director, informed the Board that the new database is anticipated to go live in January 2008 and that eventually Board meeting material will be available via the internet. The new database will also enable physicians to apply for initial licensure and license renewal via the Board's website. The Agency's Licensing Office received 197 licensure applications since the Board's August 2007 meeting, which is a decrease from last year. The Agency issued 336 licenses in the past two months and is averaging 28 days to process the applications. It is currently taking MD applicants approximately 49 days to complete the application. Mr. Miller said that the new database will enhance the process by not allowing applications to be submitted until complete. Mr. Miller stated the number of physicians in Arizona has increased by 651, but that the number does not mean that all are located in Arizona. Mr. Miller also reported that the Investigations Office currently has 380 open cases that are under investigation and it is taking approximately 79 days to complete an investigation. He stated this is a significant improvement as it was taking approximately 180 days to complete an investigation. Mr. Miller noted that the Investigations Office is carrying a higher than average case load as there are currently two investigator positions open; however, he believes the case load will stabilize once the positions are filled. Mr. Miller informed the Board that the number of cases pending formal interview continues to decrease and; therefore, the need to hold additional Board meetings has been eliminated. Dr. Krishna thanked the Board's Legal Coordinator for the consent agreements offered to physicians as this has helped to reduce the number of formal interviews.

Mr. Miller stated this is will be his last Board meeting with the Arizona Medical Board and expressed his appreciation to the Board Members for their trust in him. He noted the agenda he had set when he started with the Agency has been very successful and that his goal for the Board to take a more proactive approach has been successful as well. He stated the Board has received great reviews on the updated guidelines for opiate prescribing and the checklist in choosing a cosmetic surgeon. He also noted the Board agenda includes the approval of the Physician Assistant Supervision Guidelines and believes this will be of tremendous value as the community continues to grow. The Board's development of the complimentary alternative medicine guidelines will go a long way helping physicians understand the Board's expectations. Mr. Miller expressed how proud he was of the guidelines and that they demonstrate how the Board has made the transition to become proactive in the community. On behalf of Staff, he said the Agency understands the magnitude in balancing the public's safety with a physician's career.

Chair's Report

Update on Structure of Attorney General's Office Representation

Dr. Martin stated he has been meeting with the Attorney General's Office along with Mr. Miller. He said their goal was to consolidate services to find a way to decrease the formal hearing case backlog, and to ensure accountability and proper representation is provided to the Board by its litigating attorneys. He informed the Board and Staff of the plan to ultimately have a supervising attorney who will provide internal advice to Staff and to Board Members, sit on the Staff Investigational Review Committee (SIRC), and draft interim orders and draft and review consent agreements for discipline. The Board's other attorneys will not have day-to-day duties for the Board and their attention will be solely focused upon litigation. Dr. Martin said this will reduce the backlog of cases at formal hearing and also provide accountability. He stated the Attorney General's Office has been willing to work with the Board to move forward with the plan and that a representative from the Attorney General's Office will be addressing the Board at its December 2007 meeting to allow the Board Members the opportunity to ask questions. Dr. Martin concluded in stating the supervising attorney will be responsible for assigning cases to the other attorneys and ensuring they are held accountable for the quality of their work.

Executive Director Hiring Committee Status Report

Dr. Martin informed the Board that the posting for the Executive Director position closed on Friday, October 5, 2007. The Arizona Department of Administration (ADOA) submitted more than sixty applications for the Committee's review and Dr. Martin stated the Committee intends to interview approximately the top ten candidates, and invite the top four candidates for interviews with the full Board. Dr. Martin requested input from Board Members as to what type of Executive Director (ED) they are looking for and what qualifications they feel are most important. Board Members suggested emailing their suggestions to the Chair, but Ms. Cassetta reminded the Board that this would be considered polling which is a conflict with the open meeting laws. Dr. Martin said he would advise the Board once a process is developed for submitting their suggestions.

Dr. Martin spoke on behalf of the Board in expressing their appreciation to Mr. Miller and presented him with a certificate of appreciation from the Governor's Office. Dr. Martin noted the Board's accomplishments during Mr. Miller's term as ED stating that when Mr. Miller first came to the Board, there were more than 1,500 open cases under investigation. At that time, it took the Agency approximately 326 days to complete an investigation. Dr. Martin noted that this was a dramatic improvement in helping to protect the public and providing services to the physicians of Arizona. Mr. Miller expressed that it was a tremendous honor in allowing him to serve as ED and stated that due to Staff's efforts, the Agency is running very smoothly.

Litigator Report

Dean Brekke, Assistant Attorney General, addressed the Board and stated there are an inordinate number of cases being received at the Attorney General's Office.

Judicial Review Decisions re:

Hara Misra, M.D.: MD-02-0713A: Dr. Krishna recused himself from discussion on this case. Mr. Brekke advised the Board that the court of appeals ruled that Dr. Misra was deprived of due process because he was not allowed to review peer review materials that were only at issue because the Board's consultant mentioned them to the Board for the purpose of informing the Board that the physician had told a different story during peer review. Mr. Brekke recommended a formal interview for the limited purpose of adding into the record Dr. Misra's response regarding the peer review material. Dr. Petelin confirmed that Board Members will also be capable of reviewing the same material as Dr. Misra prior to the interview or hearing. Dr. Martin was concerned with privileged information and questioned the process for upcoming cases. Mr. Brekke informed the Board that it is restricted just to this particular case.

MOTION: Dr. Martin moved to reschedule the formal interview with the physician for the limited purpose of adding to the physician's testimony regarding the peer review materials.
SECONDED: Ms. Proulx
VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent.
MOTION PASSED.

John S. Truitt, M.D.: MD-03-0378A: Mr. Brekke informed the Board that this case resulted in a Letter of Reprimand for inappropriate treatment. He stated this case went to the court of appeals which found that Dr. Truitt was denied his due process

rights because he was not allowed to cross examine witnesses during his formal interview. Mr. Brekke informed the Board that the formal interview notice has been amended to make it clear that if physicians wish to cross examine witnesses they must select a formal hearing. Mr. Brekke stated that Dr. Truitt may be willing to sign a consent agreement to settle the matter and recommended the Board offer a consent agreement to the physician. Dr. Krishna reminded the Board that when this case initially came before the Board, Board Members were in agreement that the conduct rose to the level of discipline.

MOTION: Dr. Krishna moved to offer the physician a consent agreement for Letter of Reprimand. If the physician declines, forward the case to formal hearing.
SECONDED: Dr. Goldfarb
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board Member was absent from the meeting: Mr. Eckstrom.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

Kenneth Fisher, M.D.: MD-04-0236A: Mr. Brekke stated this case went to the Maricopa Superior Court where it was determined that the findings of fact in the final Order were not sufficient to support the conclusions of law. The judge found a due process violation in that Dr. Fisher had the right to ask questions of the medical consultant who reviewed this case. Mr. Brekke reminded the Board that this has been rectified by the current waiver that physicians sign when accepting the invitation for formal interview. Mr. Brekke said the Board may invite the physician for formal interview or instruct Staff to offer the physician a consent agreement for an Advisory Letter with non-disciplinary CME in dermatology treatment of skin lesions. Dr. Krishna noted that the physician had the opportunity to ask questions of Board Members or Staff through the Chair during formal interview. Dr. Krishna understood that the consent agreement was for an Advisory Letter, but felt the matter rises to the level of discipline.

MOTION: Dr. Krishna moved to offer the physician a consent agreement for a Letter of Reprimand. If the physician refuses, forward the case to formal hearing.
SECONDED: Dr. Petelin

Dr. Petelin noted that the physician had previously been offered a consent agreement but refused. Dr. Krishna said the court sent the case back to the Board because of due process issues. Dr. Krishna also recommended the Board re-offer the physician the consent agreement to exercise his due process rights. Dr. Petelin suggested offering an Advisory Letter. Dr. Krishna stated this case rises to the level of discipline and an Advisory Letter is not appropriate. Dr. Pardo noted the case would not be forwarded back to the Board if the physician refuses as it would be forwarded to formal hearing.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board Member was absent from the meeting: Mr. Eckstrom.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

Approval of Physician Assistant (PA) Supervision Guidelines

Mr. Miller presented the PA Supervision Guidelines and stated the proposed guidelines make it clear that PAs cannot practice independently, all of the PA's patients become the patients of the supervising physician (SP), and that the SP is responsible for the quality of care delivered to the patient. Mr. Miller stated this should help improve the quality of supervision. During the process, the Subcommittee realized that many SPs do not understand their responsibilities. Dr. Goldfarb said that through meetings and through listening to stakeholders, the guidelines have become a very strong document and sets out for both the Arizona Medical Board and the Arizona Regulatory Board of Physician Assistants exactly what is expected for PA Supervision. Dr. Martin expressed his appreciation to Dr. Goldfarb, Subcommittee Members, and Staff for their hard work in developing the guidelines.

MOTION: Dr. Martin moved to approve the Physician Assistant Supervision Guidelines.
SECONDED: Dr. Lee
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

Approval of Annual Fees

According to statute, the Board must approve its annual fees every year. Mr. Miller recommended the Board accept the current fees as the fees will remain unchanged.

MOTION: Dr. Lee moved to approve the Board's Annual Fees.
SECONDED: Dr. Schneider
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

Update of Office Based Surgery Rules

Mr. Miller informed the Board that he recently met with stakeholders and the meetings went very well and that any concerns were successfully addressed. He said these items have been submitted to the Governor's Office and are scheduled to be reviewed December 4, 2007. He stated there is no action needed by the Board at this time.

Update of Plan of Action for Offsite Meeting and Current Projects

For Completing the Office Based Surgery Rules process and Educating the Physicians and Patients

Mr. Miller informed the Board that the Rules will become effective between December 2007 and March 2008. He said this reflects a huge accomplishment for the Board that will greatly improve patient safety as physicians performing office-based surgeries using sedation continues to grow.

For Distributing the Physician Supervision of PAs Guidelines and Educating the Physicians and PAs

Mr. Miller said these guidelines will be disseminated to licensees and the public once approved by both Boards. He said the guidelines thoroughly cover all aspects of PA supervision.

For Proposing to Create a Committee to Research and Prepare an Omnibus Licensing Bill for 2009 Legislative Session to Address License Portability, Endorsement, Telemedicine, Consultation and Emergency Licenses and Necessary Regulatory Changes in the Event of a USMLE Disruption

Mr. Miller recommended the Board to create a committee to create an omnibus bill with stakeholder involvement. This bill will be for next year's legislative session.

For Developing a Substantive Policy Statement on Pre-operative and Post-operative Ophthalmic Care

Mr. Miller stated the Board still needs to address the issue of ophthalmologic care to clearly understand the standard of care versus the standard of practice. He said he would like the Board to develop guidelines to clearly identify the standard of care.

For Developing a Substantive Policy Statement on Physicians' Scope of Practice and Delegation Authority

During the Offsite Meeting, the Board established a committee to develop a substantive policy statement on physicians' scope of practice. He asked that the committee meet before the legislative session begins in January 2008. He said the Board regulates competency, not scope of practice. He also said there needs to be some community comfort in knowing how non-surgeons become surgeons.

For Developing a Substantive Policy Statement on Wrong-site, Wrong-level or Wrong-patient Care

Dr. Goldfarb said he will be working with Staff to develop this.

For Developing a Comprehensive Physician Health Program

Mr. Miller said Board Members will work to determine what the Board Physician Health Program will look like and how it will be run.

For Educating Physicians on What Every Physician and PA Needs to Know About Consent

Mr. Miller said physicians and PAs are still not appropriately obtaining informed consent. He said this continues to be an issue that the Board sees frequently.

For Communicating the Board's Guide and a Checklist for Patients to use when choosing a Cosmetic Surgeon

This guide is available on the Board's website. This was created in an attempt to alleviate the problem with cosmetic procedures being performed by non-surgeons. Mr. Miller stated the Board has received accolades for posting this information on the website, especially in light of recent cases involving plastic surgeons.

For Educating Physicians on their Duty to Report Suspected Child Abuse

Mr. Miller stated the Attorney General issued a formal opinion on this statute and the threshold for reporting suspected child abuse is now extremely low. Mr. Miller also stated this is an extremely important decision for physicians because it is a felony or misdemeanor if ignored.

Review and Approval of Proposed Statutory Language

Licensing Fees

Mr. Miller said statute requires the Board to set out its fees annually. Unlike other boards, the Board is required to set them by voting on them annually and in rule. Mr. Miller noted that the rule writing process is extensive and often does not keep up with statutory change. He said the legislature meant for the Board to consider the fees every year, not write them into rule. By amending statute, the Board would be included on a list of exempt Boards who do not have to put the licensing fees in rule.

Good Faith Protection for Board Evaluation Facilities from Civil Damages

Ms. Cassetta stated this issue concerns the liability for facilities and individuals who conduct evaluations for the Board during investigations.

On-line Training for Licensure and Re-licensure

Ms. Cassetta stated that if the Board uses the word "examination" or "test" in the statute implementing their online training, it may not be well received by the community. Dr. Krishna noted there was a portion of the application that referred to the licensee reading and understanding the statutes and asked that this be incorporated into the online training.

Disclosure of Documents to Physician During an Investigation

Ms. Cassetta noted there have been issues regarding the disclosure of confidential information from the Board to the physicians during the investigative process and recommended amending the statute to prohibit sharing of confidential investigative materials released to the physician during the investigative process.

MOTION: Dr. Krishna moved to approve the proposed statutory language.
SECONDED: Dr. Mackstaller
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

Approval of Minutes

MOTION: Dr. Krishna moved to approve the August 8-9, 2007 Regular Session Meeting Minutes, Including Executive Session, August 9, 2007 Summary Action Meeting Minutes, Including Executive Session, August 20, 2007 Summary Action Teleconference Meeting Minutes, August 20, 2007 Special Teleconference Meeting Minutes, and the September 7, 2007 Board Offsite Meeting Minutes.
SECONDED: Dr. Pardo
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

REVIEW OF EXECUTIVE DIRECTOR (ED) DISMISSALS

MOTION: Ms. Griffen moved to uphold the ED dismissal for item numbers 1,2,3,4,5,7,8,9,10,11,12,14, and 15.
SECONDED: Dr. Mackstaller
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		RESOLUTION
1.	MD-06-0410A	J.C.	ALBERT F. OLIVIER, M.D.	Uphold ED Dismissal

Dr. Olivier spoke during the call to public and briefly summarized the case. He requested the Board uphold the ED Dismissal as the patient was given the appropriate care in this matter. JC also spoke during the call to public stating that he had been experiencing pain and swelling postoperatively which caused him to file the complaint with the Board. He was concerned that he was not able to obtain an x-ray that was taken immediately following surgery.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		RESOLUTION
2.	MD-06-0981A	J.J.	PAUL M. PETELIN JR, M.D.	Uphold ED Dismissal

Dr. Petelin recused himself from this case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		RESOLUTION
3.	MD-06-0965A	D.K.	CATHERINE E. SANDER, M.D.	Uphold ED Dismissal

DK spoke during the call to public and gave a brief overview of the case. She was concerned that there were discrepancies with what she was told and what was indicated in the medical record and that Dr. Sander indicated in the medical record that she was drug seeking. She said she feels Dr. Sander falsified her medical record and said that it has been difficult for her to have this removed from her record.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		RESOLUTION
4.	MD-06-0980A	T.G.	MATTHEW C. ZIEMIANSKI, M.D.	Uphold ED Dismissal
5.	MD-06-0267A	R.H.	ANDREW P. ROYSTER, M.D.	Uphold ED Dismissal
6.	MD-06-0796A	D.D.	MICHAEL E. GRANBERRY, M.D.	Uphold ED Dismissal

Dr. Lefkowitz recused himself from this case. DD spoke during the call to public. DD questioned why he was offered a lifetime enhancement program prior to surgery after numerous examinations, but he was informed postoperatively he no longer qualified for the program. Gerald Moczynski, M.D., Medical Consultant, summarized the case for the Board. He said Dr. Granberry was not selling the enhancement program and this program was offered at the clinic in which Dr. Granberry worked. Dr. Goldfarb commented that this was a consumer issue and Dr. Krishna questioned whether Staff should continue the investigation to see if DD may receive a refund. Ms. Cassetta said Staff can inform DD of his options. Dr. Mackstaller noted that the documentation DD filled out prior to the procedure indicated a $200.00 refund for patients who no longer qualify following surgery.

MOTION: Dr. Lee moved to uphold the ED Dismissal.
SECONDED: Dr. Pardo
VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent.
MOTION PASSED.

Dr. Lee instructed Staff to inform DD of the documentation with regards to the refund.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		RESOLUTION
7.	MD-06-0814A	C.E.	TEMITOPE F. SOARES, M.D.	Uphold ED Dismissal

Dr. Soares addressed the Board during the call to public. He said he did his best to respond to the Board during the course of the investigation. He said his limited involvement in this patient's care was blotting blood with gauze and cutting sutures.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		RESOLUTION
8.	MD-06-0814B	C.E.	KATHERINE K. LIM, M.D.	Uphold ED Dismissal

Dr. Lim was present and spoke during the call to public. She verified that Dr. Soares served only as an assistant during the matter. She said she was the attending physician who performed the majority of the surgery. Mr. Barry Halpern, attorney for Dr. Soares, and Dr. Lim addressed the Board during call to public. Mr. Halpern referred the Board to documentation submitted prior to the meeting and requested the Board uphold the ED dismissal.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		RESOLUTION
9.	MD-06-0897A	K.V.	BRUCE M. COULL, M.D.	Uphold ED Dismissal
10.	MD-07-0084A	J.R.	ALICIA K. GUICE, M.D.	Uphold ED Dismissal
11.	MD-06-0900A	P.W.	DANIEL H. DOWNS, M.D.	Uphold ED Dismissal
12.	MD-07-0289A	G.P.	CRAIG G. GROSS, M.D.	Uphold ED Dismissal

GP spoke during the call to public. She was concerned the individuals interviewed by Staff during the investigation were not under oath. She said she was never contacted during the investigation, but was prepared to answer any questions for the Board.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		RESOLUTION
13.	MD-07-0281A	R.S.	BRIAN G. HAWKINS, M.D.	Uphold ED Dismissal

Dr. Hawkins addressed the Board during call to public and briefly summarized the case for the Board. He asked that the Board uphold the recommendation to dismiss this case as he treated the patient appropriately and met the standard of care. RS also spoke during the call to public and stated Board Staff failed to fully investigate and review the circumstances in this matter. Dr. Krishna pulled this case for discussion because he was concerned with the amount of Toradol administered to RS who presented with a history of kidney failure. The medical consultant who reviewed this case opined the same, but found Dr. Hawkins met the standard of care.

MOTION: Dr. Krishna moved to uphold the ED Dismissal.
SECONDED: Dr. Schneider
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		RESOLUTION
14.	MD-07-0016A	J.G.	NESTOR N. NAZARENO, M.D.	Uphold ED Dismissal
15.	MD-07-0129A	H.D.	DANIEL T. MIHALYI, M.D.	Uphold ED Dismissal

MOTION: Dr. Martin moved to accept Advisory Letters on item numbers 2, 3, 18, 20, 21, 22, 23, 24, 25, and 26.
SECONDED: Dr. Lee
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

ADVISORY LETTERS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-06-0327A	P.H.	PATTI A. FLINT, M.D.	23855	Issue an Advisory Letter for removing excess tissue from the wrong side. The violation is a minor or techincal violation that is not of sufficient merit to warrant disciplinary action.

Ms. Rhonda Needham, Dr. Flint's attorney, was present and spoke during the call to public. She gave the Board a brief overview of the case and explained why it was before the Board. She noted that each medical consultant who reviewed this case found no deviations from the standard of care and requested the Board reconsider their recommendation of an Advisory Letter. Dr. Pardo pulled this case for discussion and noted Dr. Flint had been before the Board previously for similar issues. Dr. Petelin summarized the case for the Board and commented the patient was dealt a disservice and actual harm was identified. Dr. Pardo said this seemed like a wrong-site surgery issue.

MOTION: Dr. Pardo moved to reject the Advisory Letter and invite Dr. Flint for a Formal Interview.
This motion was not seconded and therefore failed.

Dr. Lee suggested offering Dr. Flint a consent agreement for a Letter of Reprimand and then invite her for a formal interview if she did not sign the consent agreement. Dr. Sems informed the Board that a consent agreement could not be offered because there were no facts established to identify any violation of the Medical Practice Act. The Board was concerned that there was an attempt to correct the pre-existing asymmetry of PH's breasts, but Dr. Flint removed the tissue from the smaller breast which caused the

asymmetry to become much greater post-operatively. Staff informed the Board that Dr. Flint believed she made an error in dictation. Dr. Goldfarb said he was not sure there was much to be gained by inviting her for the formal interview.

MOTION: Dr. Mackstaller moved to accept the Advisory Letter for removing excess tissue from the wrong side. The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
SECONDED: Dr. Lee
VOTE: 9-yay, 1-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-07-0020A	D.W.	EUGENE L. PARK, M.D.	32287	Issue an Advisory Letter for failure to evaluate a cancer patient with new onset back pain more aggressively. The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
3.	MD-07-0090A	AMB	ANDRE MCNULTY, M.D.	35376	Issue an Advisory Letter for inadequate medical records for not documenting a pelvic exam. This is a one time omission that does not rise to the level of discipline.
4.	MD-07-0200A	AMB	R. LANE TASSIN, M.D.	25048	Dismiss.

Dr. Goldfarb stated he knew Mr. Gaines, but it would not affect his ability to adjudicate the case. Dr. Tassin addressed the Board during the call to public. He questioned how the Board could judge him and take action against his license when the Board does not know him personally. He said he learned from this experience and he has become more cautious and conservative in his current practice. Mr. Ed Gaines also spoke during the call to public. He asked that the Board reconsider the proposed Advisory Letter as Dr. Tassin has learned from this experience and has since changed his practice. Dr. Wolf summarized the case for the Board. Staff found Dr. Tassin deviated from the standard of care by failing to personally examine the patient and by failing to order a computed tomography (CT) scan to examine the patient's abdominal pain. Dr. Petelin spoke against the Advisory Letter and noted the patient presented to the emergency room with no symptoms of a perforated colon. Dr. Petelin said the standard of care does not require the physician to personally examine the patient when he/she is being seen by another qualified healthcare provider. Dr. Petelin concluded by saying the autopsy findings supported that the patient had a setting for a spontaneous perforation and this was not apparent at the time Dr. Tassin saw the patient.

MOTION: Dr. Petelin moved to Dismiss the case.
SECONDED: Dr. Lee

Dr. Pardo stated the diagnosis was difficult to deal with and said that she no longer thought the nurse involved should be referred to the Arizona Board of Nursing. Dr. Pardo commented the nurse is capable of practicing independently and was not practicing outside of her scope of practice.

VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-07-0324A	AMB	R. RANDALL GRACE, M.D.	10020	Dismiss.

Dr. Petelin spoke against the Advisory Letter in items 5-17 with the exception of 7 and 9, in which he was recused. He noted these cases were similar and involved the same PAs. Dr. Petelin noted that most, if not all, of the physicians took remedial action to rectify their mistakes. Dr. Petelin spoke in favor of dismissing cases 5-17 except 7 and 9, on which he was recused. The Board noted there were no complaints of patient harm in these cases. Dr. Petelin said the patients would have been exposed to greater danger if the physicians had used other staff that was not as well trained. Staff informed the Board that the PA Board recently took action against the two PAs by issuing both letters of reprimand. The Board noted that the recently-developed PA Supervision Guidelines are on the Board's agenda for approval. Dr. Pardo opined that as a professional, it is the physicians' responsibility to know what the statutes and requirements are for their profession. Dr. Krishna spoke in favor of the Advisory Letters in saying that this is a clear violation of statute.

MOTION: Dr. Petelin moved to dismiss items 5-17 with the exception of 7 and 9.
SECONDED: Dr. Mackstaller
VOTE: 6-yay, 4-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

MOTION: Dr. Mackstaller moved to dismiss items 7 and 9.
SECONDED: Ms. Griffen
VOTE: 5-yay, 4-nay, 0-abstain, 1-recuse, 2-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-07-0329A	AMB	HAROLD H. HASTON, M.D.	22900	Dismiss.
7.	MD-07-0336A	AMB	RICHARD J. HARDING, M.D.	2337	Dismiss.

Dr. Petelin was recused from this case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-07-0457A	AMB	SUNDEEP S. PATEL, M.D.	31155	Dismiss.
9.	MD-07-0334A	AMB	RAYMOND F. SHAMOS, M.D.	13612	Dismiss.

Dr. Petelin was recused from this case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
10.	MD-07-0322A	AMB	CURTIS A. ERICKSON, M.D.	21163	Dismiss.
11.	MD-07-0333A	AMB	DEREK VON HAAG, M.D.	32835	Dismiss.
12.	MD-07-0323A	AMB	JAMES S. HAWKINS, M.D.	31965	Dismiss.
13.	MD-07-0321A	AMB	ROGER J. HUCEK, M.D.	19766	Dismiss.
14.	MD-07-0327A	AMB	YARITZA PEREZ SOTO, M.D.	34183	Dismiss.
15.	MD-07-0326A	AMB	PAUL D. MCKERNAN, M.D.	17534	Dismiss.
16.	MD-07-0330A	AMB	NILKANTH B. RANADE, M.D.	33001	Dismiss.
17.	MD-07-0325A	AMB	CHARLES T. WILLIAMS, M.D.	12804	Dismiss.
18.	MD-07-0067A	P.S.	VICKY H-Y CHEN YANG, M.D.	29341	Issue an Advisory Letter for failing to properly prescribe Allopurinol. There is insufficient evidence to support disciplinary action.
19.	MD-07-0185A	J.B.	ALAN N. GORDON, M.D.	31462	Issue an Advisory Letter for failing to address complications that occurred while treating a patient for cervical cancer. This is a one time occurrence that does not rise to the level of discipline.

LB, the patient's husband, spoke during the call to public. He said that he was instructed by Dr. Gordon to ignore the patient's abnormal lab report. He said this caused his wife to go into septic shock and subsequently died. He commented that Dr. Gordon should suffer the consequences due to his negligence. LB, the patient's daughter, also spoke during the call to public. She said she was concerned and fearful of the quality of care Dr. Gordon delivered to his patients. She said Dr. Gordon washed his hands of her mother's life and her death was caused by his ability to walk away and not care. She encouraged the Board to look into his practice to make sure he does not do this again. JB, the patient's cousin, also addressed the Board during the call to public. She said Dr. Gordon continued to tell the patient's family he was tired and they were calling him too much. He told them they were over-reacting and there was nothing he could do for them. She said she was amazed that any healthcare provider could talk to a distraught family the way he did. Dr. Martin pulled this case for discussion. Dr. Haas summarized the case for the Board. She said the patient's positive blood cultures were not addressed appropriately and this delayed her treatments for malignancy; however, the delay in diagnosis may not have changed the outcome. She also said there were no signs of advancement of the disease and the treatment administered was at its maximum. Dr. Schneider opined that the treatment was appropriate. Dr. Krishna opined there was a lack of communication in this case.

MOTION: Dr. Krishna moved to accept the Advisory Letter for failing to address complications that occurred while treating a patient for cervical cancer. This is a one time occurrence that does not rise to the level of discipline.
SECONDED: Dr. Schneider
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
20.	MD-07-0423A	D.G.	MARK S. TONG, M.D.	13429	Issue an Advisory Letter for failing to obtain a GC/Chlamydia culture on an up-to-date culture media. This was a one time technical error that does not rise to the level of discipline.
c21.	MD-07-0045A	J.S.	ANGELA R. MERZENICH, M.D.	29075	Issue an Advisory Letter for inadequate medical records and failing to follow up with a patient complaining of recurring testicular pain. This is a one time occurrence that does not rise to the level of discipline.
22.	MD-07-0134A	AMB	RODNEY S. IANCOVICI, M.D.	28530	Issue an Advisory Letter for failure to supervise a PA involved in prescribing opiates to a previously known methadone addict. There is insufficient evidence to support disciplinary action.
23.	MD-07-0391A	AMB	NORMAN GOLDSTEIN, M.D.	7934	Issue an Advisory Letter for obtaining a fee by fraud, deceit, or misrepresentation. The felony plea was a one time occurrence and does not rise to the level of discipline.
24.	MD-07-0146A	R.P.	GERALD B. WALMAN, M.D.	10481	Issue an Advisory Letter for failure to document an informed consent. This was a minor technical violation that does not rise to the level of discipline.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
25.	MD-07-0223A	H.R.	MACELLE L. NEUWIRTH, M.D.	34319	Issue an Advisory Letter for using Tylenol with Codeine for pain control in a one week old neonate. This is a one time occurrence and does not rise to the level of discipline.
26.	MD-07-0371A	R.C.	PHILLIP J. HUSBAND, M.D.	19722	Issue an Advisory Letter for failure to provide patient records in a timely manner and inadvertently releasing another patient's records within the record released.
27.	MD-07-0551A	AMB	LAURA A. NOVELL, M.D.	33201	Issue an Advisory Letter for disciplinary action taken by another state. The physician has demonstrated remedial action that has mitigated the need for disciplinary action.

Dr. Pardo pulled this case for discussion. Dr. Pardo noted this case stemmed from another state's action against Dr. Novell's license, but questioned if the action was disciplinary or non-disciplinary. Dr. Pardo said she was concerned that there was limited information in the case. She said it was hard for her to evaluate the case since there was not enough information to help determine how egregious Dr. Novell's conduct was. Dr. Martin agreed. Pat McSorley, Case Review Manager, informed the Board that the Staff Investigational Review Committee (SIRC) determined that because the action was reported to the National Practitioner's Databank then it was a reportable offense. Staff directed the Board to Dr. Novell's response that outlined the events that occurred from the underlying case. Board Members noted the region of the lab report was difficult to see and the problem would not lie with the radiologist, but rather with the admitting surgeon. Dr. Goldfarb opined that it would be incumbent on the trauma surgeon to keep a neck collar on a patient until a fracture is ruled out. He found it difficult to find the radiologist at fault and Dr. Krishna agreed.

MOTION: Dr. Krishna moved to issue the Advisory Letter for disciplinary action taken by another state. The physician has demonstrated remedial action that has mitigated the need for disciplinary action.
SECONDED: Dr. Pardo

Dr. Mackstaller noted that other states in which Dr. Novell is licensed did not take action and questioned if the case should be dismissed. Ms. Cassetta said the issues Dr. Novell was cited on by the other state would be considered unprofessional conduct in Arizona. Dr. Krishna commented the Advisory Letter would be appropriate as it enabled the Board to track Dr. Novell.

VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

MOTION: Dr. Krishna moved to accept the proposed Consent Agreements in items 1-7.
SECONDED: Ms. Proulx
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

OTHER BUSINESS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-06-1026A	AMB	MIRIAM A. ARCE, M.D.	15645	Accept proposed consent agreement for Letter of Reprimand for failing to recognize acute onset dyspnea as a chest pain equivalent for inadequate evaluation and for inadequate medical records.
2.	MD-06-0988A	AMB	BERNARD J. MILLER, M.D.	7421	Accept proposed consent agreement for Letter of Reprimand for failing to note a possible septal infarct on the EKG preoperatively, for failing to obtain cardiac clearance prior to elective surgery and for performing a tonsillectomy without having a sleep study and/or trial of CPAP before the tonsillectomy was performed.
3.	MD-06-1038A	K.H.	ERIC J. MILLER, M.D.	19279	Accept proposed consent agreement for Letter of Reprimand for habitual intemperance, prescribing for other than therapeutic purposes, prescribing controlled substances to a family member, prescribing without first establishing a doctor-patient relationship and failure to maintain adequate medical records. Five Year Probation with MAP terms.
4.	MD-07-0018A	AMB	MAZEN H. KHAYATA, M.D.	20382	Accept proposed consent agreement for Letter of Reprimand for failing to remove a targeted lesion during surgery, failing to inform the patient that he was unsuccessful in removing the lesion, failing to review the pathology report, and for failing to renew the treatment plan when the tumor was not removed.
5.	MD-07-0198A	AMB	MOUSTAFA E. ALAMY, M.D.	24095	Accept proposed consent agreement for a Decree of Censure for disciplinary action taken by the State of California for rendering inappropriate and unnecessary treatment for six patients and for failure to maintain adequate medical records. Civil penalty of $5,000.
6.	MD-07-0532A	AMB	HOWARD D. ELLIS, M.D.	16727	Accept proposed consent agreement for a Letter of Reprimand for disciplinary action taken by the State of Kansas regarding inadequate

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
					medical records, making a false statement in connection with the practice of medicine and for failing to report an adverse action.
7.	MD-07-0193A	AMB	WILLIAM K. KVIEN, M.D.	15772	Accept proposed consent agreement for a Letter of Reprimand for engaging in sexual relationships with patients, for making a false or misleading statement to the Board, for failing to maintain adequate medical records, for habitual intemperance, and for making a false statement in connection with the practice of medicine. Five year Probation requiring Dr. Kvien to have a female chaperone present when examining female patients. Dr. Kvien shall apply to the Board to request that the chaperone requirement be lifted. Within six to 12 months, Dr. Kvien shall return to PRC for a one week follow up evaluation. Within one year, Dr. Kvien must obtain 10 hours CME in ethics and 10 hours CME in boundary issues. For two years, Dr. Kvien shall undergo random urine drug screens, abstain from all mood altering substances, and undergo therapy as recommended by PRC. Dr. Kvien shall incur all the costs of the monitoring.
8.	MD-05-0053A	AMB	PAMELA A. MORFORD, M.D.	17926	Accept proposed consent agreement for a Surrender of License.

Dr. Goldfarb was recused from this case. Emma Mamaluy, Assistant Attorney General, presented the case to the Board. She said Dr. Morford had appeared before the Board previously and has a history of discipline and recommended the Board accept the proposed consent agreement for Surrender of License.

MOTION: Dr. Krishna moved to accept the proposed consent agreement for Surrender of License.
SECONDED: Ms. Griffen
VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
9.	MD-04-1423A	AMB	CLARENCE E. RODRIGUEZ, M.D.	14409	Accept proposed consent agreement for a Surrender of License.

Ms. Mamaluy presented this case to the Board. Dr. Krishna noted this case involved drug related issues. Ms. Mamaluy recommended the Board accept the proposed consent agreement for Surrender.

MOTION: Dr. Krishna moved to accept the proposed consent agreement for Surrender of License.
SECONDED: Ms. Griffen
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
10.	MD-04-1308A	J.H.	GEOFFREY P. RADOFF, M.D.	9881	Reject the proposed consent agreement for the Advisory Letter and offer the physician a consent agreement with the same facts as the Advisory Letter, for a Letter of Reprimand. If the physician declines, invite him for a formal interview.

Dean Brekke, Assistant Attorney General, presented the case to the Board. Dr. Radoff holds both an allopathic license and a homeopathic license. The Homeopathic Board of Arizona investigated this case and dismissed the complaint. Mr. Brekke said the Board is restricted to the investigation that was conducted by the Homeopathic Board. Staff recommended the Board interview Dr. Radoff, but his attorneys objected stating an interview would expand the scope of the investigation and that an interview would extend the case, which is illegal. The Attorney General's Office was able to negotiate a consent agreement for an Advisory Letter and the agreement was signed by Dr. Radoff. Mr. Brekke requested the Board accept the consent agreement.

MOTION: Dr. Goldfarb moved to go into executive session.
SECONDED: Dr. Krishna
Vote: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

The Board went into Executive Session for legal advice at 5:13 p.m.
The Board returned to Open Session at 5:25 p.m.
No deliberations or discussions were made during Executive Session.

Dr. Goldfarb noted that when this case was first brought to the Board, the Board felt that the circumstances were such that the case should be referred to Formal Hearing. Mr. Brekke stated he did not agree with the opposing counsel's argument that the Board could not take further action and that the Board can only act based upon the Homeopathic Board's investigation. He stated the Board would be on firm legal foundation to take the case to formal hearing if the Board rejects the Advisory Letter, but felt the consent agreement was the most expeditious and appropriate way to resolve the case. Dr. Martin questioned whether the opposing parties would be in agreement with a consent agreement for a Letter of Reprimand. Dr. Krishna was in agreement as the case rises to the level of disciplinary action. Dr. Goldfarb said he noted seven separate issues that, when combined, could be

egregious. The Board agreed to offer Dr. Radoff a Letter of Reprimand using the same wording from the Advisory Letter consent agreement. If Dr. Radoff refuses the Letter of Reprimand, the Board instructed Staff to invite him to Formal Interview.

MOTION: Dr. Krishna moved to reject the proposed consent agreement for the Advisory Letter and offer the physician a consent agreement with the same facts as the Advisory Letter, for a Letter of Reprimand. If the physician declines, invite him for a formal interview.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Dr. Pardo, Ms. Proulx, and Dr. Schneider. The following Board Member was absent: Mr. Eckstrom.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
11.	MD-03-0014A	AMB	ZEV FAINSILBER, M.D.	22634	Accept consent agreement for Letter of Reprimand.

Emma Mamaluy, Assistant Attorney General, presented this case to the Board. She said the basis for the Letter of Reprimand included an A.R.S. §32-1401 (27)(q) violation for potentially harmful conduct, an A.R.S. §32-1401 (27)(t) violation for making a false statement and an A.R.S. §32-1401 (27)(z) violation for sexual misconduct with a patient. She requested the Board accept the proposed consent agreement for Letter of Reprimand because it is appropriate as it continues to protect the public.

MOTION: Dr. Goldfarb moved to accept the proposed consent agreement for Letter of Reprimand.
SECONDED: Dr. Krishna
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Dr. Pardo, Ms. Proulx, and Dr. Schneider. The following Board Member was absent: Mr. Eckstrom.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
12.	MD-06-0187A	C.S.	ELA M. TIMBADIA, M.D.	16679	Grant the motion for rehearing or review for the limited purpose to modify the findings of fact #17 and #18.

Mr. John Drazkowski, Dr. Timbadia's attorney, addressed the Board during the call to public. He said he had concerns with the facts as written in Dr. Timbadia's Letter of Reprimand. He noted a number of inconsistencies in the record and said the one key deviation the Board focused on during Dr. Timbadia's interview was the amount of time spent in the operating room. He said this may be misleading to the public. He asked the Board to grant Dr. Timbadia another formal interview to address the facts that are inconsistent and to discuss the facts that seem to be omitted from the record. Dr. Timbadia also addressed the Board during the call to public. She said that in retrospect, she wished she had taken extra steps for a timelier follow up. She briefly summarized the case for the Board and outlined actions she felt she could have done differently. Dr. Rice was present and spoke during the call to public on behalf of Dr. Timbadia. Dr. Rice was the anesthesiologist involved in this patient's care. He said Dr. Timbadia did not jeopardize the patient and he never felt the need to stop her. He asked the Board to reduce the action or dismiss the case. Ms. Cassetta noted changes in findings #17 and #18 as proposed in a memorandum to the Board from Ms. Froedge. Dr. Petelin spoke against any reconsideration for rehearing and stated some of the statements made today were not entirely correct. Dr. Martin stated they would have to reconsider the case for the limited purpose to modify the findings of fact.

MOTION: Dr. Krishna moved to grant the motion for rehearing or review for the limited purpose to modify the findings of fact for #17 and #18 as proposed in a memorandum to the Board from Ms. Froedge.
SECONDED: Dr. Petelin
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
13.	MD-07-0247A	AMB	MARVIN L. GIBBS, , M.D.	13736	Deny Motion for Rehearing or Review.

Anne Froedge, Assistant Attorney General, presented the case to the Board and recommended the Board deny Dr. Gibbs' motion for rehearing or review.

MOTION: Dr. Krishna moved to deny Dr. Gibbs' Motion for Rehearing or Review.
SECONDED: Dr. Lee
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
14.	MD-06-0062A	AMB	STEPHEN P. SUTTON, M.D.	28812	Grant the motion for rehearing or review for the limited purpose to modify the findings of fact as recommended by Board legal counsel and for the Board to review articles submitted by Dr. Sutton.

Emma Mamaluy, Assistant Attorney General, presented the case to the Board and asked the Board to grant the rehearing or review for the limited purpose of editing certain findings of fact as proposed.

MOTION: Dr. Krishna moved to grant the motion for rehearing or review for the limited purpose to modify the findings of fact as recommended by Board legal counsel.
SECONDED: Dr. Lee
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

Ms. Mamaluy requested the Board reconsider the matter for further discussion.

MOTION: Dr. Krishna moved to reconsider the matter.
SECONDED: Dr. Lee
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.

Ms. Mamaluy said there were two main issues that she discussed in her confidential memorandum to the Board. She requested the Board enter into executive session so that she may further elaborate.

MOTION: Dr. Krishna moved to go into executive session.
SECONDED: Dr. Goldfarb
Vote: 11-yay, 0-nay, 0-abstain, 1-recuse.
MOTION PASSED.

The Board went into Executive Session for legal advice at 5:58 p.m.
The Board returned to Open Session at 6:05 p.m.
No deliberations or discussions were made during Executive Session.

MOTION: Dr. Krishna moved to grant the motion for rehearing or review for the limited purpose to modify the findings of fact as recommended by Board legal counsel and for the Board to review articles submitted by Dr. Sutton.
SECONDED: Dr. Lee
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
15.	MD-06-0950A	AMB	MOHAMMAD Z. QURESHI, M.D.	8269	Deny Motion for Rehearing or Review.

Anne Froedge, Assistant Attorney General, presented the case to the Board. She referred the Board to a confidential memorandum containing legal advice.

MOTION: Dr. Lee moved to deny the motion for rehearing or review.
SECONDED: Dr. Krishna
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
16.	MD-06-0927A	P.C.	NEIL TRACHTENBERG, M.D.	10078	Accept draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for performing a procedure to which the patient did not consent.
17.	MD-06-0554A	AMB	CESAR VILLARREAL, M.D.	30915	Accept draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for committing a misdemeanor involving moral turpitude.

Mr. David Derickson, Dr. Villarreal's attorney, addressed the Board during call to public and asked the Board to reconsider the sanction. He stated that he hoped the Board would reject the Letter of Reprimand and send the case back for further discussion as there is not sufficient evidence to support the findings of fact. Ms. Cassetta informed the Board that based on correspondence with Mr. Derickson, she had modified findings of fact 16 and 18. She referred the Board Members to a confidential memorandum for further explanation.

MOTION: Dr. Lee moved to accept the Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for committing a misdemeanor involving moral turpitude as amended.
SECONDED: Ms. Proulx
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

MOTION: Dr. Lee moved to accept the Draft Findings of Fact for items 16 and 18.
SECONDED: Ms. Proulx
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	RESOLUTION

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
18.	MD-06-0847A	M.K.	UNEN D. HSU, M.D.	8373	Accept draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure for inappropriate narcotic prescribing with a 15 Year Probation restricting him from prescribing narcotics. The physician may petition the Board within 5 years for termination of the restriction. The Interim Consent Agreement will remain in effect until the effective date of this Order.
19.	MD-07-0195A	AMB	JOHN C. MORGAN, M.D.	25871	Deny Motion for Review of ED Referral to Formal Hearing.

Staff recommended the Board deny Dr. Morgan's motion for rehearing or review.

MOTION: Dr. Goldfarb moved to deny the motion for rehearing or review.
SECONDED: Dr. Krishna
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

Wednesday, October 10, 2007

Call to Order
The meeting was called to order at 9:30 a.m.

Roll Call
The following Board Members were present: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Dr. Pardo, Ms. Proulx, and Dr. Schneider. The following Board Member was absent: Mr. Eckstrom.

Call to Public
Statements issued during the call to public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-07-0183A	AMB	SHASHI J.GOEL, M.D.	24977	Issue an Advisory Letter for allowing a physician whose license was suspended access to patients. This was a minor or technical violation. Non-disciplinary CME in ethics addressing practice ownership management issues.

Dr. Shashi Goel was present with legal counsel, Mr. Stephen Myers of Myers and Jenkins. Marlene Young, Case Manager, summarized the case for the Board. Dr. Shashi Goel was found to have been involved in Dr. Sudhir Goel's violation of a Board Order by aiding in the unlicensed practice of medicine and by allowing Dr. Sudhir Goel to represent himself under the alias of "Dr. Om" while his license was summarily suspended. Dr. Shashi Goel admitted to Staff that she knew Dr. Sudhir Goel used the alias of Dr. Om when introducing himself to individuals. During the course of the investigation, Dr. Shashi Goel resigned from her position at Quick Visit, owned by her and Dr. Sudhir Goel. Dr. Shashi Goel gave a brief overview of her medical background. She said she is true to the profession of medicine and has strong boundaries. Following her husband's suspension, they were legally advised that it was safe to open a practice having Dr. Sudhir Goel serve as the office administrator even without holding a valid medical license. She said it was shocking to learn of this case as she was unaware of her husband's alleged conduct. She has since removed him from the clinic during patient care hours and has resigned as medical director of Quick Visit. Dr. Krishna led the questioning. Dr. Shashi Goel said she was aware of Dr. Sudhir Goel's suspension of his license by the Arizona Medial Board, but was not aware he would have access to the patients serving as the office administrator at the clinic. She also said she did not recall any staff informing her of the conduct by Dr. Sudhir Goel. She said that during the beginning stages of opening the clinic, she did not have a direct conversation with staff regarding Dr. Sudhir Goel's license status or restrictions. She claimed Dr. Sudhir Goel personally spoke with staff regarding his practice restriction. Dr. Shashi Goel's physician assistant (PA) resigned from the clinic complaining that she did not feel comfortable working at the clinic because it was unsettling and was taking too long to obtain approval from the Board for her to practice under Dr. Shashi Goel's supervision. Dr. Shashi Goel said the PA did not directly say it was due to Dr. Sudhir Goel's involvement in the clinic. Dr. Goldfarb noted there was a note written in the chart of a patient regarding cellulitis by Dr. Sudhir Goel. She said the notation in the chart was to indicate an "Emergent Visit" and she did not recognize this until after the investigation. The Board noted Dr. Shashi Goel's office contained a sign with both her and Dr. Sudhir Goel's names with "M.D." after both. She said the sign was at her other office location and she was focused more on opening the new office. In closing, Mr. Meyers pointed out that the PA did not identify her concerns regarding Dr. Sudhir Goel to Dr. Shashi Goel. He said there was no testimony to support the allegations that Dr. Shashi Goel's medical staff knew of Dr. Sudhir Goel's license status. He opined the sanction recommended by Staff was excessive and asked the Board to lower the level of discipline.

Dr. Krishna said he was concerned with the callousness of Dr. Shashi Goel in allowing her husband to have contact with patients. However, he found no violation of unprofessional conduct and he could not find any reason to discipline her with regard to her interview under oath.

MOTION: Dr. Krishna moved for dismissal.
This motion was not seconded and therefore failed.

Dr. Mackstaller noted the legal advice Dr. Shashi Goel received prior to opening the Quick Visit Clinic. She stated this demonstrated that Dr. Goel knew the importance of her husband's sanction. Dr. Mackstaller spoke in favor of an Advisory Letter.

MOTION: Mackstaller moved to issue an Advisory Letter for allowing a physician whose license was suspended access to patients. This was a minor or technical violation. Non-disciplinary CME in ethics addressing practice ownership management issues.
SECONDED: Dr. Petelin

Dr. Petelin spoke in favor of the motion. He said it was blatant that the sign was there and was misleading to patients. Dr. Mackstaller said she understood why Dr. Shashi Goel failed to realize the front sign with her husband's name on it. Dr. Lee spoke against the motion and stated he believed her conduct rises to the level of discipline. He said that from the evidence, it was hard for him to believe that she was not aware of what was going on in her practice. He said from the preponderance of evidence, she was made aware and ignored the issue knowing it was a violation. Dr. Goldfarb also spoke against the motion. He stated Dr. Shashi Goel violated A.R.S. §32-1401 (27)(q) by allowing Dr. Sudhir Goel the opportunity to have access to patients and said he found this egregious. Dr. Pardo also spoke against the motion. She said she found it hard to believe that Dr. Shashi Goel did not know how Dr. Sudhir Goel would behave in the clinic knowing he would have access to patients. Dr. Lefkowitz commented that there was an obvious element of cultural misunderstanding.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Ms. Griffen, Dr. Krishna, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, and Ms. Proulx. The following Board Members voted against the motion: Dr. Goldfarb, Dr. Lee, Dr. Pardo, and Dr. Schneider. The following Board Member was absent: Mr. Eckstrom.
VOTE: 7-yay, 4-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-06-1042A	N.G.	ALAN C. SACKS, M.D.	9475	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to maintain adequate medical records.

Dr. Sacks was present without legal counsel.

MOTION: Dr. Mackstaller moved to accept the Motion for Good Cause submitted by the physician prior to the interview.
SECONDED: Dr. Krishna
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

William Wolf, M.D., Medical Consultant, summarized the case for the Board. Staff found Dr. Sacks deviated from the standard of care by failing to discuss treatment options with less potential scarring for a patient with pseudoptosis. Staff also found Dr. Sacks deviated from the standard of care by failing to conduct a history and physical examination of NG. Staff identified Dr. Sacks' prior Board history as a legal aggravating factor. Dr. Sacks stated he did not deserve such a severe sanction as he appropriately treated NG. He noted a few inaccuracies in the Board's findings. Dr. Petelin led the questioning. Dr. Sacks told Staff that there was no one else present during NG's examinations. Dr. Petelin noted the record indicated NG requested a full DD size breasts upon presentation to Dr. Sacks. Dr. Petelin also noted the examination and history was only related to NG's breasts. In this case, Dr. Sacks made no attempt to try to discuss the fact that NG's breast would end up being very large or attempt to advise her to consider a smaller size. There was no elaboration to a note in the medical record regarding NG's family history of cancer. Dr. Sacks said he did not feel he needed to know where the cancer was unless it was associated with NG's breasts. Dr. Petelin informed Dr. Sacks that colon cancer is associated with breast cancer. In closing, Dr. Sacks said he initially takes the history and discussion with the patient and it is usually documented in the chart. He claimed he did discuss the breast size with NG and it is noted in her medical record. He believed he provided her with the requested breast size, but she must have changed her mind afterward. He said there are many facts in the case file that are untrue or inaccurate and stated he properly and fully informed NG prior to surgery. He concluded in asking the Board to lower the discipline recommended by Staff. Dr. Petelin clarified with Staff that the only information Staff obtained from the complainant was her initial complaint as Staff was unable to contact her following the filing of the complaint. Dr. Petelin stated the review of NG's history in the medical record as demonstrated was poor and his postop visits were inadequate. However, Dr. Petelin said there was not enough evidence to support a violation of A.R.S. §32-1401 (27)(q).

MOTION: Dr. Petelin moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(e)- Failing or refusing to maintain adequate records on a patient.
SECONDED: Dr. Lee
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.

MOTION PASSED.

Dr. Petelin said due to the inability to comfortably sustain some of the other allegations that were made, he could not support a Decree of Censure recommended by Staff. However, he stated he did feel this rises to the level of discipline due to Dr. Sacks' prior Board history.

MOTION: Dr. Petelin moved for a Draft Finding of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to maintain adequate medical records.
SECONDED: Dr. Schneider

Dr. Mackstaller said it seemed as though the complaint originated from a young girl who wanted a breast augmentation but chose too big of a size. She spoke against the motion and stated that the Letter of Reprimand would be too severe a sanction.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Martin, Dr. Petelin, Dr. Pardo, Ms. Proulx, and Dr. Schneider. The following Board Member voted against the motion: Dr. Mackstaller. The following Board Member was absent: Mr. Eckstrom.
VOTE: 10-yay, 1-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

Call to Public

Statements issued during the call to public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-06-0936B	AMB	PARVEZ P. JESSANI, M.D.	22709	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to seek the course of the patient's nausea and vomiting, failure to aggressively treat symptomatically the issue of the persistent hypotension and acidosis, failure to recognize the acidosis, failure to use standard tests and monitoring modalities to assess the effectiveness of the treatment course, and for failure to seek further information or appropriate consultation to clarify the disease as to whether the disease could affect the patient's present and presenting condition.

Dr. Jessani was present with legal counsel, Ms. Sandra J. Rogers of Campbell, Yost, Clare and Norell PC. Kathleen Coffer, M.D., Medical Consultant, summarized the case for the Board. Staff found Dr. Jessani deviated from the standard of care by failing to appropriately treat patient LB for propionic acidemia, lack of intervention in this hypotensive patient with persistent acidosis, persistent nausea and vomiting. Dr. Jessani also deviated from the standard of care by failing to consult the proper specialist. Dr. Jessani explained to the Board his medical background and a brief summary of the case. He stated there was an error with the nurse's charting in the medical record. In summary, he said that he was not informed of the patient's condition with regard to the blood drop and that when he saw her, she was stable. He said LB was not established with a specialist as he thought she had a chronic problem that was stable. Dr. Lee led the questioning and noted Dr. Jessani's working diagnosis on LB upon admission was nausea, vomiting, dehydration and propionic acidemia. Dr. Lee clarified that Dr. Jessani did not seek the cause of LB's sickness. Dr. Jessani said he did not think she was in any fluid deficit situation because she did not demonstrate any symptoms. Dr. Lee referred Dr. Jessani to the medical record and requested clarification of his interpretation of LB's lab work. Dr. Jessani noted it was important to monitor LB's output. LB had bathroom privileges, but there was no charting of this in the medical record. Dr. Jessani said he obtained a gastroenterology (GI) consult to help in treating LB's nausea and vomiting. LB's blood pressure may have contributed to her nausea and vomiting. He said that at the time of treating her, he was not familiar with propionic acidemia. Dr. Lee noted that other than the GI consultation, he did not seek any additional consultation on this patient.

Dr. Mackstaller noted that when LB presented to Dr. Jessani, she presented with a history of propionic acidosis. Dr. Jessani said he presumed that propionic acidemia was not the presenting problem. Dr. Jessani said he would have done things differently had he been familiar with propionic acidemia. Dr. Mackstaller commented that he owed it to LB to aggressively seek more information of her illness. Dr. Petelin said he was concerned that when Dr. Jessani realized he did not have the fund of knowledge in treating LB's propionic acidemia and that he did not make a greater effort to educate himself more thoroughly about the disease. Dr. Petelin was disturbed by Dr. Jessani's management of LB in this case. In closing, Ms. Rogers said she personally tried to research propionic acidemia in adults, but could not find much information. She stated most physicians have only heard of it in children because most do not live to adulthood. She said LB was stable when Dr. Jessani saw her and he was never notified of any complications. Dr. Lee said the standard of care is to seek the cause of the patient's nausea and vomiting, to aggressively treat propionic acidemia, and to use standardized testing. He said additionally, if one is not familiar, one should seek further information to see how it would affect the patient. He found Dr. Jessani did not meet these standards. Dr. Lee identified potential harm as the continued, prolonged non-treatment in LB's first few days. He said the actual harm was LB's death.

MOTION: Dr. Lee moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public. A.R.S. §32-1401 (27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Dr. Petelin

Dr. Mackstaller said a normal heart rate is 60-99 beats per minute. The closer it is to 100, the closer it is to tachycardia. As an internist, she had no problem with Dr. Jessani not understanding the diagnosis of propionic acidemia, but agreed with Dr. Lee that he had the obligation to look it up and seek help and that he should have consulted with a nephrologist.

VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

Dr. Lee said there were many red flags that were not attended to. He said this case rises to the level of discipline.

MOTION: Dr. Lee moved for a Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to seek the cause of the patient's nausea and vomiting, failure to aggressively treat symptomatically the issue of the persistent hypotension and acidosis, failure to recognize the acidosis, failure to use standard tests and monitoring modalities to assess the effectiveness of the treatment course, and for failure to seek further information or appropriate consultation to clarify the disease as to whether the disease could affect the patient's present and presenting condition.
SECONDED: Dr. Petelin
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Dr. Pardo, Ms. Proulx, and Dr. Schneider. The following Board Member was absent: Mr. Eckstrom.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

Dr. Martin instructed Staff to refer the nurse involved in this case to the Arizona Board of Nursing.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-06-0067A	T.A.	CHARANJIT S. DHILLON, M.D.	11273	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for fraudulent billing and failure to provide the medical record to the subsequent treating physician. One Year Probation with 20 hours CME in billing and coding and documentation to support the billing and coding. Probation to terminate upon completion of CME.

Dr. Dhillon was present with legal counsel, Mr. Richard H. Rea of Shughart Thomson Kilroy, P.C. Tina Geiser, Case Review Assistant Manager, summarized the case for the Board. Staff found Dr. Dhillon double billed Blue Cross Blue Shield with no supporting documentation, failed to provide patient TA's medical records to the subsequent treating physician, and charged a fee for services not rendered. Dr. Dhillon said that in looking back he realized the CPT codes he used for billing were excessive for the specific visits and that he has since changed his practice. He said he has reviewed the written policy of the Board from the Board's website with regard to medical records. Dr. Krishna led the questioning. Dr. Dhillon explained to the Board his office procedures with regard to medical records and billing. Dr. Dhillon said he keeps multiple charts on patients who present with multiple complaints. He recognized that he did not spend as much time with patients to be billing a CPT code of 99215. He said he was not aware at the time that it would be considered falsifying by the billing code that did not match for an office visit. Dr. Dhillon said his understanding of billing code 99244 is that the patient had to be referred by another physician or themselves. Dr. Krishna questioned what his protocol is for request of medical records. His office staff is to send the record once the request is verified as being valid. He said he is only contacted to review them if there is an issue. He said he understood that the ultimate responsibility lies with him, if the records are not released. Dr. Lee noted that Dr. Dhillon had been issued an Advisory Letter in 1997 for inappropriate billing. In closing, Mr. Rea stated fraud and deceit requires an intent that he suggested is not present here. He suggested the matter did not rise to the level of discipline. He said Dr. Dhillon voluntarily reimbursed for the billing that was incorrect. Mr. Rea suggested the Board issue an Advisory Letter, but if the Board is inclined to take disciplinary action, he requested they do not find any violation of A.R.S. §32-1401 (27)(t) or A.R.S. §32-1401 (27)(v) because there was no bad intent. Dr. Krishna opined Dr. Dhillon appeared a competent physician, but said knowledge of billing is also important. He noted Dr. Dhillon admitted that he knew there was a violation of the statutes when he billed patients inappropriately.

MOTION: Dr. Krishna moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(u)-Charging a fee for services not rendered or dividing a professional fee for patient referrals among health care providers or health care institutions or between these providers and institutions or a contractual arrangement that has the same effect. This subdivision does not apply to payments from a medical researcher to a physician in connection with identifying and monitoring patients for a clinical trial regulated by the United States food and drug administration, A.R.S. §32-1401 (27)(v) Obtaining a fee by fraud, deceit or misrepresentation. A.R.S. §32-1401 (27)(rr) - Failing to make patient medical records in the physician's possession promptly available to a physician assistant, a nurse practitioner, a person licensed pursuant to this chapter or a podiatrist, chiropractor, naturopathic physician, osteopathic physician or homeopathic

physician licensed under chapter 7, 8, 14, 17 or 29 of this title on receipt of proper authorization to do so from the patient, a minor patient's parent, the patient's legal guardian or the patient's authorized representative or failing to comply with title 12, chapter 13, article 7.1.
SECONDED: Dr. Mackstaller
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

Dr. Krishna noted this was a repeated violation and said he would like to see Dr. Dhillon obtain CME hours in billing and coding.

MOTION: Dr. Krishna moved for Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for fraudulent billing and failure to provide the medical record to the subsequent treating physician. One Year Probation with 20 hours CME in billing and coding and documentation to support the billing and coding. Probation to terminate upon completion of CME.
SECONDED: Dr. Martin
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Dr. Pardo, Ms. Proulx, and Dr. Schneider. The following Board Member was absent: Mr. Eckstrom.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-05-0263A	J.K.	SCOTT C. FORRER, M.D.	19296	Dismiss.

Dr. Goldfarb recused himself from this case. Dr. Johan Van Dalen spoke during the call to public in support of Dr. Forrer. He said he has known Dr. Forrer for seventeen years. From his perspective, he said Dr. Forrer is a great person in his professional life as well as his personal life.

MOTION: Dr. Martin moved to go into executive session.
SECONDED: Dr. Krishna
Vote: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent.
MOTION PASSED.

The Board went into Executive Session for legal advice at 3:53 p.m.
The Board returned to Open Session at 4:04 p.m.
No deliberations or discussions were made during Executive Session.

Dr. Forrer was present with legal counsel, Mr. Bryan Murphy of Burch & Cracchiolo. Dr. Coffer summarized the case for the Board. Staff found Dr. Forrer deviated from the standard of care by failing to perform an adequate history and physical examination and by performing extensive testing on JK without clear justification and unrelated to the reason for JK's neurology consultation. Dr. Forrer performed EMG/NCV testing, none of which was directed toward the clinical question that prompted the consultation with JK. Vicki Johansen, Case Manager, explained to the Board that Board staff requested Dr. Forrer provide the information regarding the nutritional product that was offered to JK. During the course of the investigation, Dr. Forrer provided false and misleading statements to the Board. Dr. Forrer failed to disclose his relationship with the sales representative at his office and his relationship with ISAGENIX. Staff did not find Dr. Forrer's delay in providing records to the Board egregious enough to support a violation of A.R.S. §32-1401 (27)(dd). Dr. Forrer said that in the course of evaluating the case, the medical records have been taken out of context. He said an appropriate evaluation, diagnostic, and assessment was undertaken and that appropriate counseling was given throughout the course of care. Dr. Martin led the questioning and noted a difference in the medical consultant's summary of the events that occurred and that of Dr. Forrer's. Dr. Forrer said the medical consultant mischaracterized how the patient arrived at his office and why she was being evaluated. Dr. Martin said Dr. Forrer has been very persistent in trying to clarify the record. Dr. Lee said he was concerned with Dr. Forrer's response regarding the relationship with the sales representative working in his office. Dr. Forrer said he did not recall ever being asked directly what his relationship in his office was with the sales representative. Ms. Johansen explained that Dr. Forrer was sent a letter requesting he provide the name of the nutritional supplement or cleansing treatment options offered during the patient's examination, including any printed material. Dr. Forrer responded, but did not provide any information with regard to his affiliation to the company or the sales representative. He did explain to the Board in September 2006 that he was a paid employee in his office. Dr. Forrer said he has no other relationship with the sales representative other than an employee relationship. In closing, Mr. Murphy said that it was worth noting that Dr. Forrer has been persistent for a reason. The medical consultant felt there was excessive testing conducted, but Mr. Murphy said their own experts opined this was not a deviation from the standard of care. He asked that the Board dismiss the case. Dr. Martin said that when looking closely at the record, there was clear evidence suggesting that there were multiple complaints by the patient that were addressed by Dr. Forrer and found no deviation from the standard of care.

MOTION: Dr. Martin moved to dismiss this case.
SECONDED: Dr. Mackstaller

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Ms. Proulx, and Dr. Schneider. The following Board Member was absent: Mr. Eckstrom. The following Board Member voted against the motion: Dr. Petelin. The following Board Member was recused: Dr. Goldfarb.
VOTE: 9-yay, 1-nay, 0-abstain, 1-recuse, 1-absent.
MOTION PASSED.

Dr. Forrer thanked the Board for restoring his honor and integrity.

FORMAL HEARING MATTER – CONSIDERATION OF ADMINISTRATIVE LAW JUDGE (ALJ) RECOMMENDED DECISION

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-07-0328A MD-07-0589A	AMB	PETER J. NORMANN, M.D.	33254	Uphold Summary Suspension. Revoke License.

K.M. was present and spoke during call to public. She explained to the Board that she underwent liposuction surgery conducted by Dr. Normann. She had to find another physician when she found out that Dr. Normann had trouble with other patient's care and she required additional surgery following her procedure with Dr. Normann. She offered to present photos to the Board along with scarring.

Dr. Normann was not present during the Board's consideration of these matters. Ms. Froedge summarized the cases for the Board and urged it to grant the state's motion to adopt as modified to separately delineate the findings of fact in the order provided by the ALJ. She said Staff had provided those findings as well as additional findings of fact that were developed at the hearing and were supported by transcripts, exhibits, and testimony at hearing. Ms. Froedge provided specific citations to the record for the changes she was requesting to the Findings of Fact. Staff requested the Board uphold the summary suspension of Dr. Normann's license and revocation so that no patient in Arizona is subjected to the substandard practices of Dr. Normann.

MOTION: Dr. Krishna moved to accept the ALJ's recommended Findings of Fact as amended in the state's motion to modify and as edited by Board Counsel.
SECONDED: Dr. Mackstaller
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

MOTION: Dr. Lee moved to accept the ALJ's recommended Conclusions of Law as amended.
SECONDED: Dr. Goldfarb
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

MOTION: Dr. Mackstaller moved to accept the ALJ's recommended Order, as amended by Board counsel and to assess the formal hearing costs.
SECONDED: Ms. Griffen

Ms. Cassetta suggested the Board to amend the Order to say the summary suspension shall remain in effect until the effective date of this Order. She also asked the Board to amend the Order to state his license is revoked at the effective date of this Order.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Dr. Pardo, Ms. Proulx, and Dr. Schneider. The following Board Member was absent: Mr. Eckstrom.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

Thursday, October 11, 2007

Call to Order
The meeting was called to order at 8:00 a.m.

Roll Call
The following Board Members were present: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Dr. Pardo, Ms. Proulx, and Dr. Schneider. The following Board Members were absent: Mr. Eckstrom and Dr. Lefkowitz.

Call to Public

Dr. W. Neil Chloupek addressed the Board during the call to public. He expressed to the Board that he felt he was unjustly charged with being impaired when the Board had no supporting evidence for the revocation of his license. All other statements issued during the call to public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
1.	MD-06-0667A	C.W.	PATRICIA L. CLARKE, M.D.	26877	Draft Finding of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to appropriately evaluate a patient with multiple medical issues and for failure to maintain adequate medical records. One Year Probation with 20 hours CME in diagnosis and treatment of fluid and electrolyte abnormalities. Probation to terminate upon completion of CME.

Drs. Martin and Lee both said that they knew Dr. Clarke but it would not affect their ability to adjudicate this case. Dr. Clarke was present with legal counsel, Mr. Stephen Myers of Myers and Jenkins. Kelly Sems, M.D., Chief Medical Consultant, summarized the case for the Board. Staff found Dr. Clarke deviated from the standard of care by recommending unnecessary treatments that were not based on the history and physical. For example, Dr. Clarke administered 3 liters of normal saline for dehydration without supporting evidence for this diagnosis. Dr. Clarke also deviated from the standard of care by failing to follow up on the abnormal CRP lab test. Dr. Goldfarb led the questioning and briefly reviewed Dr. Clarke's medical training and background. He opined that her medical record keeping was unorthodox and confusing for the reviewer. Dr. Goldfarb noted there were tests in the medical record that did not have clear supporting documentation. Dr. Goldfarb was concerned that pertinent information regarding the patient was not in the right place in the record. She said she was aware that she needed to improve her medical recordkeeping and she has since done so. She said she continued to conduct tests on CW due to his worsening state. He commented that neither of the diagnosis seemed to fit CW's symptoms. She said the notations in the record are not the actual diagnosis, it is her thought process and she had not yet diagnosed him. CW told her when he first presented that he had a history of gout. She said he was inquiring as to what his options would be for periods between gouty episodes. Dr. Clarke saw CW for a course of two months, approximately eight times. Dr. Clarke said CW would show up without appointments on a regular basis. She said that he indicated he wanted "the works". The record did indicate a lot of studies conducted and ordered by her, but CW wanted far more than that. Dr. Mackstaller was concerned that Dr. Clarke did not feel it was her responsibility in either supporting the disease or reassuring him he had none. Dr. Clarke asked the Board to understand that this was a very unique patient, she said he had a long laundry list of what he believed he was suffering from when he first presented to her office.

In closing, Dr. Clarke summarized the case for the Board. She said he presented with multiple complaints. She said the only records she was able to obtain of CWs history were psychiatric. She has since taken classes to help her improve on her medical recordkeeping. Mr. Myers referred the Board to expert witness letters in the case file submitted in support of Dr. Clarke. He said she is in the process of converting her medical records to an electronic version. Dr. Goldfarb stated the medical records are completely inadequate. He was also concerned that she had some gaps in her knowledge, particularly in the treatment for an electrolyte balance. She has shown an inability to understand some of the conditions of treating fluid and electrolyte balance. She was putting patients on medications that are not needed or indicated.

MOTION: Dr. Goldfarb moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(e)- Failing or refusing to maintain adequate records on a patient. A.R.S. §32-1401 (27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Dr. Petelin

Dr. Martin spoke in favor of the motion. He agreed with Dr. Goldfarb that the medical records are clearly inadequate and there is a lack of knowledge. Dr. Mackstaller noted that some patients are difficult and very unique, but it is the treating physician's responsibility to create boundaries. Ms. Cassetta clarified with Dr. Goldfarb that the standard of care would indicate that patients be on necessary or indicated medications. Dr. Goldfarb said Dr. Clarke deviated from this standard.

VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

MOTION: Dr. Goldfarb moved for a Draft Finding of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to appropriately evaluate a patient with multiple medical issues and for failure to maintain adequate medical records. One Year Probation with 20 hours CME in diagnosis and treatment of fluid and electrolyte abnormalities. Probation to terminate upon completion of CME.
SECONDED: Dr. Krishna

Dr. Schneider said she was concerned with Dr. Clarke's lack of boundaries. Dr. Martin pointed out that there are medical records issues and that he appreciated that Dr. Clarke is working on addressing the issue of the medical records.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Mackstaller, Dr. Martin, Dr. Petelin, Dr. Pardo, Ms. Proulx, and Dr. Schneider. The following Board Members were absent: Mr. Eckstrom and Dr. Lefkowitz.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
2.	MD-06-1002A	AMB	SCOTT A. SCHAPKER, M.D.	30606	Advisory Letter for failure to personally assess the patient in a timely fashion during labor.

Dr. Petelin was recused from this case. Dr. Schapker was present with legal counsel, Ms. Kimberly Anne Kent and Co-counsel Ms. Melinda C. Bechtel of Kent and Associates, P.L.L.C. Dr. Petelin was recused from this case.

MOTION: Dr. Krishna moved to accept the Motions for Good Cause submitted prior to the interview.
SECONDED: Dr. Lee
VOTE: 9-yay, 0-nay, 0-abstain, 1-recuse, 2-absent.
MOTION PASSED.

Ingrid Haas, M.D., Medical Consultant, summarized the case for the Board. LG had a previous cesarean section in Mexico and the records were not obtainable. LG initially indicated a cesarean section for the birth. Staff found Dr. Schapker deviated from the standard of care by failing to diagnose and treat a patient for proper delivery of a baby in a timely manner, failing to supervise and direct staff for the emergent delivery of the baby by cesarean, and by failing to perform a required cesarean section in a timely manner. Dr. Schapker stated this was his first appearance before the Board. He said he understood the severity of the allegations and their potential negative impact on his future practice. He hoped to clarify his role in the management of this patient, as he served as a consultant to a certified nurse midwife. He felt the recommendation for a Letter of Reprimand was harsh and hoped the Board would reconsider. Dr. Schneider led the questioning. He said his practice has changed tremendously since 2003 when this event occurred. In 2003, all six of the certified nurse midwives (CNMs) performed deliveries. If there was a low risk patient, the CNM would care for the patient and that d he acted as a consultant in this case. The CNM was the one who determined whether or not the patient needed a cesarean. If he had a problem with their management of the patient, he would tell them and on some cases, he would take over for them. Dr. Schneider noted that Dr. Schapker's operative report did not mention the status of the baby. Dr. Schapker said that when the baby is delivered, he hands it to the pediatrician and is not involved in the baby's care from then. Dr. Schneider noted there was a dramatic change in the fetal tracings at one point. Dr. Schapker testified that if he was there in the hospital prior to delivery, he still would not have done anything differently. LG had prenatal care with a different CNM than who had treated her while in labor. Dr. Schneider was concerned that Dr. Schapker did not present to the hospital immediately following his first phone call from the treating CNM to personally examine LG. Dr. Schapker said it is not the standard of care for an obstetrician to be in house minute-by-minute throughout all labor courses with all patients. He doesn't go to the hospital until they decide that he is needed in most instances such as this.

Dr. Schapker informed the Board that his practice now involves him personally examining patients and he no longer allows the CNMs to independently care for patients. In closing, Ms. Kent said the record was incorrect in stating that Dr. Schapker was notified that LG requested delivery of her baby. She said he was not requested to come in and perform the cesarean section when LG first presented to the hospital. She also said Dr. Schapker had no knowledge that LG requested a vaginal birth nor did the CNM convey any concerns of the patient or fetus during their phone calls. She pointed out that the medical records indicate that LG continued to request a cesarean section for birth. Dr. Schneider noted this was a complicated case and that CNMs are independent providers. She said Dr. Schapker failed to present to the hospital to evaluate or counsel the patient; therefore, she was unable to make an informed decision for delivery.

MOTION: Dr. Schneider moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Dr. Krishna

Dr. Lee spoke against the motion and said the primary care provider is responsible. He said he could not see the Board holding Dr. Schapker responsible because he served as the consultant. Dr. Schneider said she found a violation in that there was a lot of assuming that someone else counselled LG and was evaluating her. She said most vaginal deliveries are required to have a cesarean section available at all times. Dr. Krishna spoke in favor of the motion. He said that once Dr. Schapker accepted the phone call from the CNM, he accepted responsibility for LG. He said that is where the issue lies; he did not evaluate LG to see whether it was safe for her to have a normal delivery. Dr. Mackstaller noted the primary care provider was the CNM. Dr. Pardo commented that the CNM was responsible for knowing her boundaries. Dr. Lee noted there was another case where there was an obstetrician who did not come in to see the patient but was depending on a nursing staff to take care of the patient. Dr. Goldfarb opined that if a physician is called, like Dr. Schapker was in this case, there was a reason he is being asked to consult. Dr. Goldfarb said that having never seen LG before, Dr. Schapker had an obligation evaluate her because he is a level above the nursing staff. Staff clarified the sequence of events that occurred the night of LG's delivery. Dr. Haas said she believed the standard of care in 2003 would have required Dr. Schapker to present to the hospital to evaluate LG. She also said it was his responsibility to determine the cesarean section.

The Board stayed its deliberations and reopened the questioning to get clarification from Dr. Schapker as to what was discussed during his phone calls with the CNM. Dr. Mackstaller questioned what Dr. Schapker was told by the CNM during their telephone conversations and what was asked of him. He said that he was called four times and was told that LG was there initially and she was a VBAC candidate. He said he was not made aware that LG wanted a cesarean section. Dr. Martin questioned if the four phone calls were unusual in his typical practice. Dr. Schapker said that specific CNM would call for reassurance. He said there were not concerns significant enough that he was concerned for the baby's well being. Ms. Kent said sometimes the CNMs call the physicians just to talk and that is part of their teamwork. Dr. Haas referred Board Members to a note from the CNM in the medical record. The note indicated the CNM relayed information to Dr. Schapker pertaining to fetal heart tracings, LG's vomiting with fever, and that she was a VBAC patient. She opined she would have expected Dr. Schapker to see LG at that time. Dr. Martin said it is clear that the operative report was inadequate and the Board agreed that at some point, he did not understand the urgency of what was going on. Dr. Martin suggested an Advisory Letter so that this issue may be tracked. Dr. Schneider agreed. Ms. Cassetta reminded the Board that if it intended to issue an Advisory Letter, they are not required to find him in violation of statute.

VOTE: 4-yay, 5-nay, 0-abstain, 1-recuse, 2-absent.
MOTION FAILED.

MOTION: Dr. Mackstaller moved for to issue the physician an Advisory Letter for failure to personally assess the patient in a timely fashion during labor.
SECONDED: Dr. Lee

Dr. Krishna spoke against the motion and stated the record clearly indicated Dr. Schapker was aware of LG's status during labor.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Ms. Griffen, Dr. Lee, Dr. Mackstaller, Dr. Martin, Dr. Pardo, and Ms. Proulx. The following Board Members voted against the motion: Dr. Goldfarb, Dr. Krishna, and Dr. Schneider. The following Board Member was recused from this case: Dr. Petelin. The following Board Members were absent from the meeting: Mr. Eckstrom and Dr. Lefkowitz.
VOTE: 6-yay, 3-nay, 0-abstain, 1-recuse, 2-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
3.	MD-06-0358A	L.N.	STEPHEN O. MORRIS, M.D.	10800	Draft Finding of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to diagnose and monitor a patient considered to be high risk for drug abuse, inappropriate prescribing and for inadequate medical records.

Dr. Morris was present with legal counsel, Sarah l. Sato of Olson, Jantsch & Bakker, P.A. Carol Peairs, M.D., Medical Consultant, summarized the case for the Board. Staff found Dr. Morris deviated from the standard of care by failing to monitor patient JN's Tricyclic blood levels while he was on concurrent SSRIs, by prescribing a large quantity of Tricyclic Antidepressants and Ritalin to a patient known to be a risk for overdosing on drugs, by failing to perform regular mental status exams and failed to question the patient regarding potential harm to self or others, and by failing to make an adequate DSM IV diagnosis. This case came before the Board in April 2007. The Board voted to return the case for further investigation. Dr. Morris stated he felt the discipline proposed by Staff was unduly harsh and hoped it would not be issued. He outlined multiple discrepancies in the SIRC recommendation and stated he believed he met the standard of care. He said that if he failed, it would only be regarding a record violation. Dr. Lee led the questioning and noted that there is limited documentation in patient JN's medical records. Dr. Morris failed to document mental status during subsequent appointments following the initial presentation. Dr. Morris said he does conduct examinations, but fails to always document them in the medical record. Dr. Lee noted that dosage of medication seemed to increase in a short period of time. Dr. Morris agreed that he should have tried to control the medication prescribed. Dr. Morris pointed out that JN was also receiving pain medication from another treating physician for a foot injury. Dr. Lee noted the medical record lacked justification or the need for high dose of potentially dangerous drugs that Dr. Morris was prescribing to JN. There was also no documentation of the amount of medication prescribed. Dr. Morris said he believed his documentation, evaluation of the patient, and prescribing methods was adequate. Dr. Petelin noted that Dr. Morris' handwriting was fairly legible and that is not the reason for the inadequate medical records. Dr. Petelin said Dr. Morris should have limited the medication prescribed to JN because the medication could have cause JN to overdose. Dr. Morris said he only felt JN to be suicidal on one occasion. Dr. Mackstaller noted JN was seeing multiple physicians who were prescribing multiple medications to him. Dr. Morris said he followed JN very closely as JN was reporting to him multiple times a week. He also said JN was voluntarily seeking treatment, therefore, he was not able to commit him. In closing, Ms. Sato said that the record does not reflect that Dr. Morris failed to deliver hands on care to JN, although there was no simple course of treatment that could have been administered to him. Dr. Lee noted the deviations as stated above and opined that the medication prescribed may have contributed to the death of JN.

MOTION: Dr. Lee moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(e)- Failing or refusing to maintain adequate records on a patient. A.R.S. §32-1401 (27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public, and A.R.S. §32-1401 (27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.

SECONDED: Petelin
VOTE: 9-yay, 1-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

MOTION: Dr. Lee moved for a Draft Finding of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to diagnose and monitor a patient considered to be high risk for drug abuse, inappropriate prescribing and for inadequate medical records.
SECONDED: Dr. Schneider

Dr. Petelin spoke against the motion as he felt it the case rose to a higher level of discipline. He said a Decree of Censure would be more appropriate based on Dr. Morris' repetitive history. Dr. Petelin felt some of Dr. Morris' statements issued under oath were misleading. He opined Dr. Morris was using a polypharmacy to treat JN. Dr. Martin spoke in favor of the Letter of Reprimand and said he understood the deviations, but said he was not sure there was much more Dr. Morris could have done in this case.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Ms. Proulx, and Dr. Schneider. The following Board Member voted against the motion: Dr. Petelin. The following Board Members were absent from the meeting: Mr. Eckstrom and Dr. Lefkowitz.
VOTE: 9-yay, 1-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
4.	MD-06-0456A	BANNER MEDICAL CENTER	MICHAEL R. ROLLINS, M.D.	30379	Letter of Reprimand for failure to timely operate on a patient with post-operative complications.

Dr. Rollins was present with legal counsel, Mr. Stephen Myers of Myers and Jenkins. William Wolf, M.D., Medical Consultant, summarized the case for the Board. Staff found Dr. Rollins deviated from the standard of care by failing to operate on patient JH in a timely fashion when JH presented with severe abdominal pain, tachycardia and pneumoperitoneum following an elective sigmoid colectomy. Instead, Dr. Rollins waited until the following day to operate on JH after JH's condition had deteriorated substantially. Dr. Rollins also deviated from the standard of care by failing to adequately diagnose and treat a postoperative hemorrhage. Dr. Rollins noted that Dr. Mackstaller had previously raised questions about the post-op bleed that occurred shortly after the first surgery. He said JH did fairly well postoperatively and responded well to treatment by post-op day eight. He summarized the care of JH postoperatively. He said he wished he would have taken JH back to the operating room immediately. He said he is more aggressive with patients in his practice now that may appear with similar issues. Dr. Mackstaller led the questioning. Dr. Mackstaller questioned if JH was tachycardic or hypotensive during the first surgery, but Dr. Rollins did not recall. She noted that following the first surgery JH complained of a lot of pain, was tachycardic, and his blood pressure was lower than what it was pre-operatively. Dr. Rollins said he did not work up the bleeding as it was not an acute loss of blood. He explained it to be more of a slow trickle of blood. JH was brought back ten days following discharge. Dr. Morris also said he felt JH had abdominal compartment syndrome and he did not feel that a 3,000cc blood clot in the abdomen contributed to his ability to maintain his blood pressure. Dr. Rollins said JH's cause of death was due to a brain injury from cardiac arrest. Dr. Petelin noted that JH was three hundred pounds and five foot eleven. He said that in order for JH to have a decrease in his hemocratic from 46 to 20, he would have to lose approximately five liters of blood. Dr. Petelin questioned how Dr. Rollins could consider this blood loss was coming from only a slow trickle. In closing, Mr. Myers gave a brief summary of the case. He noted that Staff had originally recommended an Advisory Letter, but the Board rejected it and requested Dr. Rollins appear for formal interview. Mr. Myers said that during the malpractice case, there was no finding of a deviation. Dr. Mackstaller opined that as an internist, a hematocrit that is half of the original warrants a workup. She said she had no way of knowing for certain, but suspected JH's death to be directly related to Dr. Rollins failure to workup a rather vigorous blood loss.

MOTION: Dr. Mackstaller moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public, and A.R.S. §32-1401 (27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Dr. Petelin
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

MOTION: Dr. Mackstaller moved for a Draft Finding of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to recognize and timely diagnose and treat a postoperative complication of hemorrhage resulting in patient death.
SECONDED: Dr. Petelin

The Board was concerned that the one day delay may not have made the outcome different. Dr. Petelin opined that the problem occurred immediately on days three and four post-op. He said he believed JH was inadequately resuscitated as he did not have enough red blood cells and not enough fluid. Dr. Petelin said JH may not have arrested if more units of blood were administered to him.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board Members were absent from the meeting: Mr. Eckstrom and Dr. Lefkowitz.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

Executive Director Exit Interview

The Board went into Executive Session for legal advice and a personnel matter at 4:11 p.m.
The Board returned to Open Session at 5:51 p.m.
No deliberations or discussions were made during Executive Session.

The meeting adjourned at 5:51 p.m.

Amanda J. Diehl, Deputy Executive Director